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Maintaining State Discretion Versus Mandating
Universal Medicaid Coverage:
Renewed Federalism and a Reasonable Standard of
Care under *DeSario v. Thomas*

Danielle Teachout Uy*

I. INTRODUCTION

Medicaid, Title XIX of the Social Security Act,¹ provides medical assistance to families with dependant children, aged and blind people, and disabled individuals who do not have the financial resources to meet their medical needs.² Congress recently reduced Medicaid budgets, consequently reducing the scope of Medicaid coverage in many states.³ These economic and political developments continue to push the judiciary to examine the fundamental conflict between a state's desire to limit the scope of coverage for medically necessary treatment and Medicaid's mandate that recipients have reasonable coverage standards.

The Second Circuit's decision in *DeSario v. Thomas*⁴ created a circuit split over whether a state Medicaid agency must cover all non-experimental, medically necessary types of services when no cheaper, equally effective alternative treatment exists.⁵ The Second Circuit allows states to exercise their discretionary powers and place limits

* J.D. Candidate 2000.

1. Social Security Act, 42 U.S.C. § 1396 (1988).

2. *See id.*

3. 144 CONG. REC. H4188-01 (1998). Mr. Waxman spoke against the Republican Leadership's Budget Resolution for fiscal year 1999. He asserted that the proposed budget will destroy the medicaid program by slashing federal expenditures for medicaid and children's health by \$12 billion dollars over the next five years. *Id.* at H4223.

4. 139 F.3d 80 (2d Cir. 1998), *petition for cert. granted, vacated, and remanded sub. nom.*, *Slekis v. Thomas*, 119 S. Ct. 864 (1999).

5. *See U.S. Supreme Court Petitioned To Hear DeSario Case!* (last modified Aug. 10, 1998) <<http://www.aamr.org/NewsDeSario.html>>.

on Medicaid coverage.⁶ Conversely, the Eighth, Ninth, and Tenth Circuits require state Medicaid plans to provide all medically necessary services to eligible recipients.⁷ The Supreme Court granted the *DeSario* plaintiffs' petition for a writ of certiorari to resolve this issue.⁸

On remand a future Second Circuit holding can affect Medicaid recipients in two ways.⁹ If the Second Circuit continues to allow states to exercise their discretionary powers and limit Medicaid coverage, some recipients will have to look to private charities for some necessary care and equipment, but Medicaid will still ensure that the poorest people have an acceptable minimum level of health care coverage.¹⁰ Conversely, if the Second Circuit capitulates and mandates that states must provide all medically necessary treatment and equipment, then states may opt out of the federal-state Medicaid program leaving the poorest people in our society entirely without a federal-state health care safety net.¹¹

Part II of this Note provides an overview of Title XIX's historical developments and coverage limitations. Part III reviews the applicable Supreme Court cases cited by circuit courts on both sides of the split. Part IV reviews circuit developments and examines the courts' attempts to strike a balance between the different approaches by various states to moderate costs by limiting coverage for treatment, care, or equipment and Title XIX's mandate for a

6. See *infra* notes 62-68 and accompanying text.

7. See *infra* notes 69-102 and accompanying text.

8. See *infra* notes 113-14 and accompanying text. *DeSario* also presented the Supreme Court with the opportunity to resolve the issues of whether a state Medicaid agency may deny treatment for rare medical conditions within a mandatory or option benefit category and whether providing benefits in a federally-funded state-run program to some disabled individuals and denying those same benefits to other individuals, based on their disabling conditions, constitutes prohibited discrimination under the Americans with Disabilities Act or § 504 of the Rehabilitation Act. These issues are beyond the scope of this paper. *U.S. Supreme Court Petitioned To Hear DeSario Case!* (last modified Aug. 10, 1998) <<http://www.aamr.org/NewsDeSario.html>>.

9. See *infra* notes 113-14 and accompanying text.

10. See Bob Herbert, *Health Care Denied*, N.Y. TIMES, Sunday, July 26, 1998, at Week in Review 15. (stating that the *DeSario* decision "may impede needy individuals' medical treatment for AIDS, multiple sclerosis, cerebral palsy, and renal failure"). See also Brief for National Multiple Sclerosis Society as *Amicus Curiae* in Support of Appellants' Petition for Rehearing En Banc, *DeSario v. Thomas*, 139 F.3d 80 (2d Cir. 1998) (No. 97-6027).

11. See *infra* notes 12-15 and accompanying text.

reasonable standard of coverage. Part IV also extracts the test each circuit applies to determine whether a state has exceeded its discretion by limiting Medicaid coverage for medically necessary treatment. Part V reviews the administrative guidance issued by the Department of Health and Human Services Health Care Financing Administration (HCFA). Part VI delineates the Supreme Court's instructions to the Second Circuit when *DeSario v. Thomas* was granted certiorari, vacated, and remanded. Part VII analyzes the competing views enunciated by the circuits and responds to recently published administrative guidance. Finally, Part VIII prompts the Second Circuit to adhere to its population as a whole test and not give the HCFA's letter undue deference.

II. MEDICAID'S HISTORY AND STRUCTURE

In 1965 Congress created the Medicaid program under Title XIX of the Social Security Act.¹² Medicaid is a federal-state cooperative program providing medical assistance to indigent people and is administered by participating state agencies.¹³ Accordingly, each participating state has a wide degree of latitude in the program's implementation.¹⁴ Although participation is voluntary, states must meet federally established foundational requirements to qualify for federal funding.¹⁵

Each state must formulate its own plan establishing the medical services for which funding will be available.¹⁶ Although the plan

12. Social Security Act, 42 U.S.C. § 1396 (1988).

13. Medicaid, although established as an adjunct to the Medicare program, is distinguishable in that Medicare is fully funded and managed by the federal government. Despite this distinction it is useful to refer to the Medicare regulations for comparative purposes. Title XIX establishes two groups of needy persons: the "categorically needy" and the "medically needy." See 42 U.S.C. §§ 1396a(a)(10)(C), 1396a(a)(13)(B), 1396d(a)(1)-(5) (1988). "Categorically needy" individuals are families with dependant children, aged, blind, or disabled people who receive financial aid from federal programs. *Id.* See generally 42 C.F.R. § 435.100-.135, .700-.735 (1993). "Medically needy" individuals are people who do not qualify for some form of federal assistance but who nonetheless lack the resources to obtain adequate medical care. See 42 C.F.R. § 435.300-.350, .800-.852 (1993). See generally 42 U.S.C. §§ 1396a-1396e (1988).

14. See *id.*

15. See 42 U.S.C. § 1396a(a) (1988).

16. *Id.*

must include coverage for five mandatory treatment categories, states may choose to provide eligible recipients with additional, optional services.¹⁷ Reasonable standards for determining an individual's

17. The five mandated coverage categories are: inpatient hospital services; outpatient hospital services; laboratory and X-ray services; skilled nursing services; and physician's services. 42 U.S.C. § 1396d(a)(1)-(5) (1988). 42 U.S.C. § 1396(a) allows states to elect to provide coverage for:

Home health care services; private duty nursing services; clinic services . . . ; dental services; physical therapy and related services; prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician . . . or by an optometrist . . . ; other diagnostic, screening, preventative, and rehabilitative services; inpatient hospital services and nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases.

42 U.S.C. § 1396d(6)-(15) (1988). For this Note's purposes, home health care is the most relevant optional Medicaid service and is further defined in regulations. 42 C.F.R. § 440.70 (1993) states:

(a) "Home health services" means the services in paragraph (b) of this section that are provided to a recipient--

- (1) At his place of residence, as specified in paragraph (c) of this section; and
- (2) On his physician's orders as part of a written plan of care that the physician reviews every 60 days.

(b) Home health services include the following services and items. Those listed in paragraphs (b)(1), (2) and (3) of this section are required services; those in paragraph (b)(4) of this section are optional.

(1) Nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency as defined in paragraph (d) of this section, or if there is no agency in the area, a registered nurse who--

- (i) Is currently licensed to practice in the State;
- (ii) Receives written orders from the patient's physician;
- (iii) Documents the care and services provided; and
- (iv) Has had orientation to acceptable clinical and administrative recordkeeping from a health department nurse.

(2) Home health aide service provided by a home health agency,

(3) Medical supplies, equipment, and appliances suitable for use in the home, and

(4) Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services. (*See* § 441.15 of this subchapter.)

(c) A recipient's place of residence, for home health services, does not include a hospital, skilled nursing facility, or intermediate care facility except for home health services in an intermediate care facility for the mentally retarded that are not required to be provided by the facility under subparts F and G of part 442 of this subchapter. For example, a registered nurse may provide short-term care for a recipient in an

eligibility for medical assistance and the types of optional medical services provided must be included to comply with Title XIX's objectives.¹⁸ In addition, medical services must be sufficient in amount, duration, and scope to achieve reasonably Medicaid's purpose.¹⁹ Moreover, the Medicaid agency may not deny or reduce the amount, duration, or scope of a required service to an otherwise eligible recipient solely based on diagnosis, type of illness, or condition.²⁰ However, the agency does retain discretion to limit covered services unless medically necessary.²¹

intermediate care facility during an acute illness to avoid the recipient's transfer to a skilled nursing facility.

Id.

18. 42 U.S.C. § 1396a(a)(17) (1988). The relevant part of the statute reads:

[R]easonable standards . . . for determining eligibility for and the extent of medical assistance under the plan [must] (A) [be] consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program). . .

Id. 42 U.S.C. § 1396. Title XIX's broadly stated primary objective is to enable each State:

[A]s far as practicable . . . to furnish (1) medical assistance on behalf of families with dependant children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . .

Id.

19. 42 C.F.R. § 440.230(b) (1998).

20. 42 C.F.R. § 442.230(c) (1998).

21. 42 C.F.R. § 440.230(d) (1998). For a definition of medical necessity see *infra* notes 24-26 and accompanying text. Utilization control procedures generally refer to procedural steps necessary for coverage eligibility. For discussion and examples see *infra* notes 23 and accompanying text (delineating Connecticut's utilization control procedures and necessary

A state's decision to provide optional services must be considered in light of the statute as a whole. Although a state need only provide the minimum level of coverage, once a state's coverage goes beyond the minimum requirements, it is still bound by the statutory and regulatory language mandating reasonable standards of care for all provided services.²² Therefore, even if states opt to include additional services, such as prescription drugs or durable medical equipment, they must meet federally mandated reasonable standards of coverage.²³

Ambiguity about what treatment is a medical necessity also

procedural steps for coverage eligibility).

22. 42 C.F.R. § 440.230(b) (1998).

23. See *id.* One example of Medicaid implementation by the states is provided in *DeSario v. Thomas*, 139 F.3d 80, 83, which looks at Connecticut's program. Connecticut participates in the joint federal-state Medicaid program and complies with federal mandates by providing the five mandatory categories of coverage. See *DeSario*, 139 F.3d at 83 (citing STATE OF CONNECTICUT, DEPARTMENT OF INCOME MAINTENANCE, CONNECTICUT MEDICAL ASSISTANCE PROVIDER MANUAL FOR MEDICAL EQUIPMENT, DEVICES AND SUPPLIES § 189.D ("Map Manual"). Connecticut additionally provides "home health care services" for all Medicaid recipients. Federal regulations define home health care services to include "[m]edical supplies, equipment, and appliances suitable for use in the home." 42 C.F.R. § 440.70(b)(3) (1998). In doing so, Connecticut interprets durable medical equipment as a subset of home health care. *DeSario*, 139 F.3d at 83 (citing MAP Manual § 189.B that defines durable medical equipment ("DME") as follows:

DME means equipment which meets all of the following requirements:

- a. Can withstand repeated use
- b. Is primarily and customarily used to serve a medical purpose
- c. Generally is not useful to a person in the absence of illness or injury
- d. Excludes items that are disposable.)

Connecticut implemented its Medicaid program by limiting DME coverage to items listed in the Department's fee schedule. See *DeSario*, 139 F.3d at 83. Connecticut's program requires Medicaid recipients to submit requests for DME through an approved vendor along with a physician's prescription. *DeSario v. Thomas*, 963 F. Supp. 120, 125 (D. Conn. 1997). Prior authorization for payment will be granted only if the equipment is itemized on the fee schedule. *Id.* Connecticut lacks both regular procedures for periodically updating the fee schedule and a formal feedback procedure promoting input from Medicaid recipients regarding potential additions to the fee schedule. *Id.* at 126. The Medical Equipment, Devices, and Supplies fee schedule, adopted in June 1993, and revised in June 1996, is the exclusive list of items Connecticut's Medicaid program will provide to Medicaid recipients. *Id.* Between June 1993 and June 1996, no items were added to or removed from the fee schedule. *Id.* In addition, the MAP Manual specifically excludes certain equipment and appliances from coverage, such as room-size humidifiers, purifiers, and dehumidifiers, as well as air conditioners, and stair glides from DME. *Id.*

complicates states' efforts to reduce overall coverage while attempting to maintain federally mandated minimums.²⁴ Congress used the term medical necessity in the appropriations section of the Medicaid statute.²⁵ This section sets aside federal funds for individuals with income and resources insufficient to meet the costs of necessary medical services.²⁶ Despite statutory references to medical necessity, Congress has failed to provide state agencies with any statutory or regulatory definition.²⁷ Therefore, the determination of what treatment is medically necessary is left to physicians, participating states, and the courts.

III. APPLICABLE SUPREME COURT CASES

The circuit courts cite two United States Supreme Court cases,

24. The Supreme Court in *Beal v. Doe*, suggested that medical necessity also contributes to establishing the minimum level of service and coverage required under the statute by stating, "[S]erious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage." 432 U.S. 438, 444 (1977).

25. 42 U.S.C. § 1396 (1994). The Appropriations section reads:

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

Id.

26. *Id.* § 1396, 1396(a)(10)(C)(i) (1994).

27. See Edward Hirschfield & Gail Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3 (1996). The article concludes that whether medical services are in fact medically necessary for a particular patient is often unclear due to the imprecision of medical science. *Id.* at 5, 19-21. However, when medical necessity was a matter determined between a patient and her doctor the impact of this imprecision was minimized by the fact that the patient's interests were paramount. *Id.* at 5. The emergence and dominance of private health insurance and health maintenance organizations changed cost benefit analysis to the whole covered population based on the limited resources available to the group. *Id.* at 35. Although this article looks to private insurance schemes, the analysis is analogous to a public scenario. A federal/state Medicaid program places participating states in a similar predicament where the individual patient's needs may be subordinated to the needs of the group as a whole. Hirschfield and Thomas criticize this trend and call for increased disclosure by private plans to inform potential buyers and to decrease the economic leverage that health plans have over physicians. *Id.* at 49-50.

*Beal v. Doe*²⁸ and *Alexander v. Choate*,²⁹ to support divergent readings of Title XIX.³⁰ In 1977 the Supreme Court decided *Beal v. Doe*.³¹ In *Beal* female Medicaid recipients challenged Pennsylvania's regulation denying coverage for nontherapeutic abortions and limiting coverage to medically necessary abortions.³² The Court held that Pennsylvania's regulation limiting Medicaid funding to medically necessary abortions fully comports with Title XIX's broadly stated primary objective. In addition, the Court stated that states may provide optional coverage under the federal statutory language.³³ However, the Court cautioned that "serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage."³⁴ The Court reasoned that Congress did not intend for Medicaid coverage of nontherapeutic abortions because they were unlawful in most states when it passed the statute.³⁵ Giving deference to the administering agency, the Court also looked to the Department of Health, Education, and Welfare's policy.³⁶

More recently, the Supreme Court decided *Alexander v. Choate*.³⁷ In *Alexander* a group of disabled Medicaid recipients challenged Tennessee's addition of a fourteen-day limit on inpatient hospital stays under section 504 of the Rehabilitation Act of 1973 and its implementing regulations.³⁸ The Court held that plaintiffs failed to prove a prima facie violation of the Rehabilitation Act.³⁹ The Court reasoned that Tennessee's fourteen-day limitation still provided

28. 432 U.S. 438 (1977).

29. 469 U.S. 287 (1985).

30. The Eighth, Ninth, and Tenth Circuits rely on *Beal v. Doe*, while the Second Circuit relies on *Alexander v. Choate*.

31. 432 U.S. 438.

32. *Id.* at 441.

33. *Id.* at 447.

34. *Id.* at 444. See *supra* note 18 for the statute's objective.

35. 432 U.S. at 447.

36. *Id.* (citing *New York Dept. of Soc. Serv. v. Dublino*, 413 U.S. 405, 421 (1973)). The *Beal* court specifically noted that, "the Department of Health, Education, and Welfare . . . takes the position that Title XIX allows—but does not mandate—funding for such abortions." *Id.*

37. 469 U.S. 287.

38. *Id.* at 289.

39. *Id.* at 309.

handicapped individuals meaningful access to Medicaid benefits.⁴⁰ The Court also stated that Medicaid programs do not guarantee that recipients will receive a level of health care precisely tailored to their particular needs.⁴¹ Instead, the *Alexander* Court viewed Medicaid benefits as a package of health care services serving the population as a whole.⁴² This prompted the Court's additional note that the fourteen-day limitation was in the best interests of all Medicaid recipients because ninety-five percent of all Medicaid recipients were fully served under this limitation.⁴³

IV. APPROACHES TO RECONCILING A DENIAL OF MEDICALLY NECESSARY CARE WHILE MAINTAINING REASONABLE STANDARDS UNDER TITLE XIX

Congress failed to define medical necessity within Title XIX. In addition, states have considerable latitude in the implementation of state Medicaid plans.⁴⁴ Therefore, the duty has fallen on the judiciary to resolve disputes between a state's desire to reduce coverage to limit costs and Medicaid recipients' rights to coverage for medically necessary treatment, services, or equipment. Consequently, circuit courts devised different tests to determine when denial of coverage for physician-determined medically necessary care unacceptably reduces Medicaid coverage.⁴⁵ The decisions created a split between the Second Circuit and the Eighth, Ninth, and Tenth Circuits. The Second Circuit permits states to limit Medicaid coverage to those items delineated on a fee schedule, even if a treating physician deems non-listed equipment or treatment medically necessary.⁴⁶ Conversely, the tests enunciated by the Eighth, Ninth, and Tenth Circuits require

40. *Id.* at 302. "Evidence indicated that, if nineteen days of coverage were provided, 16.9% of the handicapped, as compared to 4.2% of the nonhandicapped, would not have their needs for inpatient care met." *Id.* at 290 n.3.

41. *Id.* at 303.

42. *Id.* at 303-04.

43. *Id.* at 303.

44. See *supra* notes 12-20 and accompanying text.

45. Because few cases address the issue of medically necessary coverage for durable medical equipment, this Note includes cases involving abortions, organ transplants, AIDS medication, and sex reassignment surgery.

46. See *infra* notes 63-64 and accompanying text.

that state Medicaid plans provide all medically necessary services to eligible recipients.⁴⁷

A. *The Second Circuit*

The Second Circuit traditionally allows more conservative coverage for Medicaid beneficiaries. In *Roe v. Norton*, the court reviewed Connecticut district court's decision in a class action suit.⁴⁸ Both class representatives had purely elective abortions.⁴⁹ The district court held that Title XIX did not limit Medicaid reimbursement for abortions under a state medical assistance program to those medically necessary for the health of the patient, but permits coverage for elective abortions as well.⁵⁰ On appeal, the State of Connecticut contended that Title XIX forbids Medicaid coverage for elective abortions and only permits coverage for medically necessary abortions.⁵¹ Connecticut posited that "medically necessary services" appears in only two places in the statute, and each time the term is used, it only describes persons eligible for medical assistance under Medicaid.⁵² Although the Second Circuit rejected appellant's argument on appeal and permitted federal reimbursement for elective abortions, it did not mandate Medicaid coverage for non-medically necessary elective abortions.⁵³

The Second Circuit has recently taken a stronger position by endorsing Connecticut's fee schedule and allowing even mandatory coverage services to be excluded from Medicaid coverage. In *DeSario v. Thomas* the Second Circuit again addressed the scope of

47. See *infra* notes 82, 89, 102 and accompanying text.

48. 522 F.2d 928, 930 (2d Cir. 1975).

49. Plaintiff Roe was 26 years old and the unmarried mother of three small children. *Id.* She was seven weeks pregnant at the time the suit was instituted. *Id.* She desired an abortion to avoid further economic burdens and family complications. *Id.* Her physician in fact said the abortion was appropriate, but not medically necessary in the sense that the patient's life or health would not be threatened if the abortion were not performed. *Id.* Plaintiff Poe had an elective abortion and subsequently was refused Medicaid coverage by the State. *Id.*

50. *Id.* at 931.

51. *Id.* at 932.

52. 522 F.2d at 933. See also *supra* note 18 and accompanying text.

53. *Id.* at 937. The Second Circuit reversed and remanded the decision with respect to Connecticut's regulation's validity under Title XIX. *Id.* at 939.

coverage for medically necessary care.⁵⁴ In *DeSario* Medicaid recipients brought a class action challenging the Connecticut Department of Social Services' denial of prior authorization requests for DME.⁵⁵ The district court found that Connecticut's fee schedule improperly limited the amount, duration, and scope of medically necessary DME.⁵⁶ The district court reasoned that the current fee schedule failed to give recipients, who have been initially denied coverage, any procedure for systematically, timely, or effectively updating the fee schedule.⁵⁷ The district court also said that Connecticut's plan had inadequate mechanisms for recipients to request coverage of an otherwise unlisted item.⁵⁸

The district court focused primarily on the needs of the individual Medicaid recipient and required the state plan to meet a two-step test.⁵⁹ Following the reasoning in *Preterm*, the district court in

54. 139 F.3d 80 (2d Cir. 1998).

55. *Id.* at 83. One subclass ("Emerson subclass") challenged coverage denials for equipment (air purifier, air conditioner, and roomsize humidifier) that was specifically excluded from the fee schedule. *Id.* Both representatives suffer from multiple chemical sensitivity and their treating physicians deemed the prescribed equipment medically necessary. *Id.* The other subclass ("The DeSario subclass") challenged denials for equipment (environmental control unit) that was neither included nor specifically excluded from the fee schedule. *Id.* DeSario is a quadriplegic who requested coverage for this equipment which centrally controls many appliances and costs approximately \$7000-\$8000. *Id.* In addition, Thomas Sleakis intervened in the action; he suffered from severe skin breakdown and sought payment for an "RIK" mattress (a mattress filled with oil-based liquid and covered with exceptionally loose-fitting sheets that costs approximately \$840 a month to rent). *Id.*

56. *DeSario v. Thomas*, 963 F. Supp. 120, 130 (D. Conn. 1997).

57. *Id.*

58. *Id.*

59. *Id.* at 133. The macro-micro analysis was first applied by the First Circuit in *Preterm v. Dukakis*, 591 F.2d 121 (1st Cir. 1979).

In *Preterm* the plaintiffs challenged a portion of the Massachusetts Acts of 1978 limiting expenditures of state funds for abortions to those abortions that are "necessary to prevent the death of the mother" and for women who became pregnant due to acts of rape or incest. *Id.* at 122-23. The court held that the Act violated the Medicaid requirements. *Id.* at 127. The court first looked to language of the Medicaid statute, 42 U.S.C. § 1396a(a)(10)(C), and found no mandate among the thirty-seven listed requirements that a state plan provide all medically necessary treatment in § 1396a. *Id.* at 124-25. Therefore, the court did not want to "draw the words 'necessary medical services' from their context in the appropriations section and in effect transport them into a contents section requirement." *Id.* at 125. The court found additional guidance within § 1396d(a), which lists the five mandatory coverage categories for participating states. *Id.* See also *supra* note 17 and accompanying text. See generally 42 U.S.C. § 1396d(a).

With this analysis and the Supreme Court's mandate in *Beal v. Doe*, the *Preterm* court fashioned and applied its two-tiered test. 591 F.2d at 125. The court established that the state

DeSario said that states must first comport with federal standards on a macro level with respect to the State's legislatively defined levels of mandatory and optional coverage.⁶⁰ States must then permit the patient's treating physician to determine necessary treatment on a micro level before categorically excluding it from the fee schedule.⁶¹

On appeal the Second Circuit vacated and remanded the case.⁶² Rather than looking to the medical necessity of an item, the court held that a state does not have to fund every medically necessary item that falls within the state's definition of DME.⁶³ The court followed the Supreme Court's language in *Alexander v. Choate*, focusing on the benefits enjoyed by qualified recipients as a group.⁶⁴ The court reasoned that there is nothing in the statute or regulations mandating coverage of all medically necessary items.⁶⁵ In addition, because the State's definition of DME was found to be reasonable, Title XIX did not require Connecticut to supply equipment that falls outside that definition.⁶⁶ Moreover, the court gave great weight to the economic arguments presented by the state.⁶⁷ In doing so, the Second Circuit formulated a test—optional coverage services and even mandatory coverage services may be denied to an individual so long as the

legislature must first make a macro-level decision in determining what kinds of medical assistance are sufficiently necessary to warrant coverage under its state plan. *Id.* The court then required that the analysis continue to a second, micro-level where the recipient's treating physician must determine whether the individual patient's condition warrants the administration of a type of medical assistance available under the state's Medicaid plan. *Id.* When the court applied its test, it also considered the regulations promulgated by the Department of Health, Education and Welfare pursuant to the Medicaid Act. *Id.* at 125-26. *See also supra* notes 19-21 and accompanying text. *See generally* 42 C.F.R. § 440.230 (1998). The court concluded that when the statute and regulations were properly applied in concert to the Massachusetts law limiting Medicaid coverage for medically necessary abortions, it was "unreasonable" and "wholly inconsistent with the objectives of the Act," for Massachusetts to provide abortion services but "deny [treatment] to all those who will not die without it." 591 F.2d at 126.

60. 963 F. Supp. at 133.

61. *Id.*

62. 139 F.3d at 84.

63. *Id.* at 92.

64. 139 F.3d at 93. *See supra* notes 37-43 and accompanying text.

65. *Id.* at 92. *See also* 42 U.S.C. § 1396a(a)(17) (1998); 42 C.F.R. § 440.230(b), (d) (1998).

66. 139 F.3d at 92.

67. *Id.* at 95-98. The court focused on the "as far as practicable" language in the statute when it warned that if a state were required to provide all medically necessary services, then coverage would be unlimited and budgeting would be by blank check. *Id.*

health care provided is adequate with respect to the needs of the Medicaid population as a whole.⁶⁸

B. The Eighth Circuit

In the Eighth Circuit the court considers the individual recipient paramount and gives the treating physician ultimate discretion in determining medical necessity. The Eighth Circuit first examined the issue of Medicaid coverage and medical necessity in *Hodgson v. Board of County Commissioners*.⁶⁹ In *Hodgson* patients, physicians, and medical clinics challenged the validity of Minnesota's Medicaid statute⁷⁰ and its coverage of abortion services.⁷¹ Minnesota provides medical assistance to the financially needy under its Medicaid statute but provides medical payment reimbursements only for abortions that are medically necessary to prevent the mother's death or to terminate a pregnancy resulting from rape or incest.⁷² The court held that the Minnesota statute and its implementation were inconsistent with Title XIX.⁷³ The court reasoned that the basic criterion for determining

68. *Id.* at 93.

69. 614 F.2d 601 (8th Cir. 1980).

70. MINN. STAT. ANN. § 256B.02 subd. 8(13) (West 1978). The statute provides partial or total reimbursement for the cost of certain specified medical services for persons meeting economic eligibility requirements may receive. These services include abortion services only if one of the following conditions is met:

(a) The abortion is a medical necessity. "Medical necessity" means (1) the signed written statement of two physicians indicating the abortion is medically necessary to prevent the death of the mother, and (2) the patient has given her consent to the abortion in writing unless the patient is physically or legally incapable of providing informed consent to the procedure, in which case consent will be given as otherwise provided by law;

(b) The pregnancy is the result of criminal sexual conduct . . . and the incident is reported within 48 hours after the incident occurs to a valid law enforcement agency for investigation, unless the victim is physically unable to report the criminal sexual conduct, in which case the report shall be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct; or

(c) The pregnancy is the result of incest, but only if the incident and relative are reported to a valid law enforcement agency for investigation prior to the abortion.

Id.

71. 614 F.2d at 605.

72. *See supra* note 70.

73. 614 F.2d at 608.

Medicaid coverage is the individual recipient's medical necessity.⁷⁴

The Eighth Circuit confirmed its commitment to the individual recipient in *Pinneke v. Preisser*.⁷⁵ In *Pinneke* the Eighth Circuit ruled on Iowa's Medicaid plan that specifically excluded coverage for sex reassignment surgery.⁷⁶ The court held that Iowa's denial of Medicaid benefits for medically necessary sex reassignment surgery violated Title XIX.⁷⁷ The court reasoned that Iowa's lack of formal rulemaking proceedings or hearings was inconsistent with Title XIX's objectives, because it established an irrebuttable presumption that non-covered services can never be medically necessary.⁷⁸ The court also noted that the individual recipient's physician bears the burden of deciding the medical necessity of a treatment.⁷⁹ The decision relied on the Supreme Court's ruling in *Beal v. Doe*, emphasizing the treating physician's role in determining medical necessity under the statute.⁸⁰ In addition, the Eighth Circuit looked to Title XIX's legislative history, noting that Congress intended physicians' medical judgements to play a primary role in the determination of medical necessity.⁸¹ In doing so, the Eighth Circuit clearly enunciated a standard of placing the individual recipient as paramount by giving the ultimate discretion to the physician to

74. *Id.*

75. 623 F.2d 546 (8th Cir. 1980).

76. *Id.* at 547. The plaintiff began life as a male but was uncomfortable with life in that gender category. *Id.* She was diagnosed as having a transsexual personality. *Id.* The only medical treatment available to treat or solve the problems of a true transsexual is radical sex conversion surgery; psychoanalysis is not a successful form of treatment. *Id.* at 548-49. The plaintiff was eligible for Medicaid benefits but was refused funding for the surgery based on Iowa's Medicaid plan that specifically excluded coverage for sex reassignment surgery. *Id.* at 547.

77. *Id.* at 549.

78. *Id.*

79. *Id.* at 550.

80. 623 F.2d at 549. See *supra* notes 31-37 and accompanying text.

81. *Id.* at 549-50 (citing S.REP. NO. 404, reprinted in 1965 U.S.C.C.A.N. 1943, 1986-89). The report states in part:

The committee's bill provides that the physician is to be the key figure in determining utilization of health services—and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay. For this reason the bill would require payment could be made only if a physician certifies to the medical necessity of the services furnished.

Id. at 1986.

determine medical necessity.⁸²

C. Ninth Circuit

The Ninth Circuit established its test for determining whether a state meets Title XIX's mandate while denying care determined by a physician to be medically necessary in *Dexter v. Kirschner*.⁸³ In *Dexter* a Medicaid plaintiff brought an action challenging denial of coverage for an allogeneic bone marrow transplant.⁸⁴ Arizona's Medicaid statute does not cover allogeneic bone marrow transplants but does provide coverage for autologous bone marrow transplants.⁸⁵

82. See *Weaver v. Reagen*, 886 F.2d 194 (8th Cir. 1989). In *Weaver* a class of Medicaid eligible individuals with the Acquired Immunodeficiency Syndrome (AIDS) sued, challenging Missouri's denial of coverage for AZT, a common AIDS inhibiting drug. *Id.* at 195. The plaintiffs suffered with AIDS and certain AIDS-related complex (ARC) but did not meet the restricted medical conditions for Medicaid coverage as delineated in Missouri's adoption of the Food and Drug Administration's (FDA) labeling approval. *Id.* at 196. The FDA's label stated that AZT was "indicated for the management of certain adult patients with symptomatic HIV infection (AIDS and advanced ARC) who have a history of cytologically confirmed *Pneumocystis carinii* pneumonia (PCP) or an absolute CD4 (T4 helper/inducer) lymphocyte count of less than 200/mm in the peripheral blood before therapy is begun." *Id.* Despite the fact that the plaintiffs did not fit this FDA labeling criteria, their respective physicians prescribed AZT to prevent or retard the progression of the disease to a more serious illness. *Id.* at 196-7. The court held that Missouri's Medicaid program could not deny coverage of AZT, a non-experimental drug, to Medicaid eligible AIDS patients whose physicians certified that AZT was a medically necessary treatment. *Id.* at 200. The court reasoned that the Medicaid statute and regulatory schemes create a presumption favoring the attending physician's medical judgment when determining the medical necessity of treatment. *Id.* at 198. Missouri's reliance on the FDA approval process was insufficient to overcome this presumption. *Id.* The court asserted that neither the practice of medicine nor physicians' exercise of their best professional judgment in the interest of the patient should be limited or interfered with by the FDA labeling process. *Id.*

83. 984 F.2d 979 (9th Cir. 1992).

84. *Id.* at 981. The plaintiff suffered from chronic myelogenous leukemia, which is fatal if untreated. *Id.* The required treatment is chemotherapy and bone marrow transplant. *Id.* The only effective transplant for plaintiff's disease is to infuse a matched donor's marrow; this is a non-experimental form of treatment. *Id.*

85. The medical difference between the two procedures is that for allogeneic bone marrow transplants the patient receives matching bone marrow from a donor, whereas with an autologous bone marrow transplant, the patient receives her own marrow that had been harvested and stored for latter infusion. *Id.* at 981. The court focused on two statutes. *Id.* at 982 (citing ARIZ. REV. STAT. §§ 36-2907.A.12, 36-2907.7.F). The two statutes read in relevant part:

[T]he following health and medical services shall be provided pursuant to provider contracts awarded under this article: . . .

Medically necessary kidney, cornea and bone transplants and immunosuppressant

The court held that Arizona, as a participant in the Medicaid program, must provide assistance to all eligible participants for all medically necessary services that qualify as mandatory coverage categories but does not have to provide coverage for all discretionary Medicaid services.⁸⁶ The court reasoned that since organ transplants are not among the “required medical services,” the Arizona legislature can choose to fund one type of bone marrow transplant while refusing to fund another.⁸⁷ The court also noted that this decision was rational given the treating physician’s testimony that the two types of bone marrow transplants were similar.⁸⁸ Therefore,

medications for these transplants . . . and, beginning October 1, 1988, medically necessary liver transplants and immunosuppressant medications for these transplants. . . . No other organ transplants may be covered by the system unless specifically required by federal law.

Id. The second statute provides:

Notwithstanding subsection A of this section [of which A.R.S. S 36- 2907.A.12 is a part], beginning October 1, 1989, the director shall provide medically necessary autologous bone marrow transplants to a person defined as eligible.

Id.

86. 984 F.2d at 983.

87. *Id.* at 983-84. *See also* McCoy v. Department of Health and Welfare, 907 P.2d 110 (Idaho 1995). The plaintiff in *McCoy* suffered from morbid obesity. *Id.* at 111. Her condition resulted in other health problems including congestive heart failure, hypertension, sleep apnea, and severe joint problems. *Id.* Her physician concluded that gastric bypass surgery was medically necessary. *Id.* The Idaho Department of Health and Welfare denied coverage for treatment pursuant to a state regulation excluding coverage for all medical procedures treating obesity. *Id.* The district court affirmed the Department’s order excluding coverage because it found that it was appropriate for a state to prioritize the medical needs of its citizens and allocate funds accordingly. *Id.* The Idaho Supreme Court vacated and remanded the case, holding that the Idaho statute was an unreasonable exclusion that arbitrarily denied funding for all obesity when treatment deemed medically necessary by the individual’s physician. *Id.* at 114. The court followed the structure devised in *Preterm* and adopted a two-step test with respect to medical necessity. *Id.* at 113. First, the state must decide which non-mandatory medical services it will provide to its population. *Id.* The individual recipient’s physician then decides whether the patient requires the treatment provided by the state plan. *Id.* The court continued to follow *Preterm*’s two-step approach by focusing on whether exclusion under this analysis was reasonable and consistent with the objectives of Title XIX. *Id.* Thus, the court concluded the state’s obesity exclusion was overbroad since it could potentially exclude patient care where the medically necessary treatment was the only covered treatment for that condition. *Id.* In addition, the court found that coverage restricted to life threatening treatments is contrary to Title XIX’s objectives. *Id.* *See generally supra* notes 17-18.

88. 984 F.2d at 984. In adopting the treating physician’s testimony, the Ninth Circuit disregarded the parties’ stipulated facts stating that “autologous bone marrow transplants and allogeneic bone marrow transplants are different procedures used to treat different diseases and have different outcomes and different side effects.” *Id.*

although the Ninth Circuit gives states discretion to fund some but not all optional services, it still requires states to provide coverage to eligible participants for all mandatory coverage services.⁸⁹

D. Tenth Circuit

The Tenth Circuit requires states to fund all mandatory coverage services deemed medically necessary. In *Visser v. Taylor* the plaintiff sought a preliminary injunction against Kansas Department of Social and Rehabilitation Services for refusal to provide Medicaid coverage for a prescription drug, Clozaril.⁹⁰ A district court held that the state's refusal to cover Clozaril in its prescription drug program violated Title XIX because it was "an arbitrary reduction in the scope of that service to otherwise eligible individuals, solely on the basis of their illness or condition."⁹¹ The court reasoned that since Kansas elected to provide prescription drug coverage under its Medicaid plan, the state must maintain this service in a manner that is reasonable and consistent with the objectives of Title XIX.⁹² Kansas failed to meet these criteria because the Department's decision to exclude Clozaril infringed on the treating physician's decision making power as to whether treatment is medically necessary and eliminated funding for medical services that a qualified physician deemed medically necessary.⁹³ The court concluded that the state's failure to cover Clozaril constituted a refusal to provide prescription drug coverage for those patients whose condition could not be effectively treated otherwise.⁹⁴ A refusal based on the recipients' illness or condition,

89. *Id.* at 983.

90. 756 F. Supp. 501, 502-03 (D. Kan. 1990). Plaintiff suffered from schizo-affective disorder, depressed type as well as hallucinations. *Id.* at 503. Her physician has recommended Clozaril to treat her condition because all other drugs had become progressively ineffective and had potentially irreversible and serious side effects. *Id.* The plaintiff's doctors felt that Clozaril was the only existing drug approved by the FDA that could treat the plaintiff's schizophrenia. *Id.* at 504. In addition to trying numerous other prescription, plaintiff has also received inpatient treatment and has been hospitalized a total of fifteen times. *Id.* Hospitalization costs ran from \$150.07 to \$211.67 per day and the state bore the full cost of inpatient care. *Id.* at 505.

91. *Id.* at 507.

92. *Id.* at 506. See also *supra* note 18 and accompanying text.

93. 756 F. Supp. at 507.

94. *Id.*

such as this, violates Title XIX.⁹⁵

The Court of Appeals further clarified the Tenth Circuit's position in *Hern v. Beye*.⁹⁶ The plaintiffs in *Hern* challenged Colorado laws⁹⁷ excluding all abortions from Medicaid coverage, except those protecting the life of an expectant mother.⁹⁸ The court held that Colorado's restriction on abortion funding violated federal Medicaid mandates.⁹⁹ The court reasoned that Colorado's Medicaid program impermissibly discriminated in its coverage of abortions based on the individual recipient's diagnosis and condition.¹⁰⁰ In addition, the court reasoned that Colorado's law was inconsistent with Title XIX's basic objective of providing eligible individuals with medically necessary care.¹⁰¹ The court concluded that Title XIX and its accompanying regulations require states to fund all mandatory coverage services that are deemed medically necessary.¹⁰²

95. *Id.*

96. 57 F.3d 906 (10th Cir. 1995).

97. CO. CONST. art. V, § 50; COLO. REV. STAT. §§ 26-4-105.5, 26-4-512, 26-15-104.5; 10 COLO. CODE REGS. § 2505-10 (8.733) (1988). The relevant portion of the Colorado Constitution reads:

No public funds shall be used by the State of Colorado, its agencies or political subdivisions to pay or otherwise reimburse, either directly or indirectly, any person, agency, or facility for the performance of any induced abortion. PROVIDED HOWEVER, that the General Assembly, by specific bill, may authorize and appropriate funds to be used for those medical services necessary to prevent the death of either a pregnant woman or her unborn child under circumstances where every reasonable effort is made to preserve the life of each.

CO. CONST. art. V, § 50.

98. 57 F.3d at 907. The plaintiffs were a physician and three women's health care facilities that provide abortion services to women in Colorado. *Id.*

99. *Id.* at 910.

100. *Id.*

101. *Id.* at 910-11.

102. *Id.* at 911. See also *Ohlson v. Weil*, 953 P.2d 939 (Colo. Ct. App. 1997) (applying the Tenth Circuit's holding from *Hern* to an optional category of Medicaid coverage). In *Ohlson* the plaintiff suffered from spinal muscular dystrophy and was wheelchair bound. *Id.* at 941. She required a molded plaster body brace in order to sit up and breathe properly in her wheelchair. *Id.* The brace was not surgically implanted but was clamped to the outside of her body. *Id.* Without the brace the plaintiff would regress into a slumped position and would eventually need mechanical assistance breathing. *Id.* The plaintiff's doctor deemed the brace to be medically necessary but the Colorado State Medicaid system denied coverage. *Id.* The plaintiff challenged the validity of Colorado's Medicaid coverage denial for external prosthetic devices while it simultaneously provided Medicaid coverage for surgically implanted prosthetic devices. *Id.* at 943. See COLO. REV. STAT. ANN. § 26-4-302(1)(f) (West 1998 Cum. Supp.). The court declined to issue a holding and remanded with instructions that "state coverage only for

V. RECENT ADMINISTRATIVE GUIDANCE

The Department of Health and Human Services Health Care Financing Administration (HCFA), the administrative agency charged with overseeing the Medicaid program, recently issued an advisory letter in response to numerous inquiries regarding Medicaid coverage of DME following the Second Circuit's *DeSario* decision.¹⁰³ The letter allows states to develop a list of pre-approved items of DME as an administrative convenience but still requires states to provide a reasonable and meaningful petitioning procedure for recipients to request coverage for non-listed items.¹⁰⁴ The HCFA letter stated that failure to provide such a procedure for requesting non-listed items is inconsistent with Title XIX.¹⁰⁵ HCFA additionally advised that when evaluating a request for coverage of non-listed DME, a state may not apply a "Medicaid population as a whole" test.¹⁰⁶ The letter warned that application of this test places an unreasonable burden on the individual Medicaid recipient and effectively fails to provide any meaningful opportunity for an internal, administrative appeal.¹⁰⁷ Moreover, any list of pre-approved DME items is merely an evolving document that must be updated

surgically implanted prosthetic devices must be 'sufficient in amount, duration, and scope' reasonable to achieve the purpose of prosthetic devices in the scheme of the federal program." 953 P.2d at 944. In addition, the court outlined two general tests courts used to determine whether a service offered in part meets this federally mandated criteria. *Id.* The first test requires a service be distributed in a manner bearing a rational relationship to the underlying purpose of providing services to those greatest in need. *Id.* The second test requires that a service "meets the needs of the 'most' individuals eligible for Medicaid who have a medical need for the particular Medicaid service." *Id.* Although the court remanded the case for further proceedings, it stated that the Colorado Department of Health Care Policy and Financing currently failed to meet these tests in part because the state conceded that the plaintiff's body brace was medically necessary. *Id.* at 945.

103. Letter from Sally K. Richardson, HCFA Director, to all State Medicaid Directors (Sept. 4, 1998) (available at <<http://www.hcfa.gov/medicaid/smd90498.html>>) (clarifying the Department's policies on DME coverage under the Medicaid program and the use of coverage lists. The guidance applies to DME only and not to any other type care covered under the Medicaid program.).

104. *Id.*

105. *Id.* See generally 42 C.F.R. §§ 440.70(b)(3), 440.230(b)-(c) (1998).

106. Letter from Sally K. Richardson, *supra* note 103 (delineating the "Medicaid population as a whole" test as the individual Medicaid recipient's burden to prove that absent coverage of the item requested, the needs of most Medicaid recipients will not be met).

107. *Id.*

periodically to reflect changing technology and changing recipient needs.¹⁰⁸

According to HCFA's administrative guidance, a state complies with federal Medicaid requirements for individual requests for DME by fulfilling three criteria.¹⁰⁹ First, states must have a timely review procedure in place for hearing recipient's non-listed DME coverage requests.¹¹⁰ Second, states must provide Medicaid recipients and the general public with materials containing the process, criteria, and pre-approved list of DME.¹¹¹ Finally, states must inform beneficiaries of their right to a fair hearing to determine whether a coverage denial conflicts with Title XIX.¹¹²

VI. THE SUPREME COURT'S RESPONSE

On January 19, 1999 the United States Supreme Court granted a writ of certiorari for *DeSario*.¹¹³ The Supreme Court vacated the Second Circuit's decision and remanded the case with instructions to consider further the matter in light of the interpretive guidance issued by the HCFA.¹¹⁴

VII. AN ANALYSIS OF THE CIRCUIT COURT DECISIONS AND RESPONSE TO THE HCFA'S INTERPRETICE GUIDANCE

The Second Circuit's holding and rationale in *DeSario*¹¹⁵ is correct and consistent with the most basic federalist principles that

108. *Id.* at 2.

109. *Id.*

110. *Id.* According to the letter, the review process must employ:

reasonable and specific criteria by which an individual item of [D]ME will be judged for coverage under the State's home health services benefit. These criteria must be sufficiently specific to permit a determination of whether an item of [D]ME that does not appear on a state's pre-approved list has been arbitrarily excluded from coverage based solely on a diagnosis, type of illness, or condition.

Id.

111. *Id.*

112. *Id.*

113. *DeSario v. Thomas*, 139 F.3d 80 (2d Cir. 1998), *cert. granted and vacated sub. nom. Slekis v. Thomas*, 119 S. Ct. 864 (1999).

114. *Id.*

115. *See supra* notes 62-68 and accompanying text.

our country was founded on and that provide a basis for Title XIX.¹¹⁶ The United States, unlike countries like Canada, Sweden, and Denmark, does not constitutionally provide its citizens with the right to universal health care coverage. Instead, the United States has established and maintains Medicaid as a joint federal-state system to provide a minimum level of health care for the poorest people in our society who cannot afford privately funded medical care or group insurance and do not qualify for Medicare.¹¹⁷ Because Medicaid only aims to ensure that the poorest people in our society have a minimum standard of health care coverage, it logically follows that Title XIX does not require states to provide coverage for all medically necessary treatment, equipment, or services.¹¹⁸

Conversely, the Eighth, Ninth, and Tenth Circuits provide an overly liberal construction of Title XIX by placing the individual Medicaid recipient as paramount and giving the treating physician ultimate discretion in determining medical necessity and Medicaid coverage.¹¹⁹ This reflects a commendable, humanitarian desire to provide the best available health care to the poorest members of our society, but if logically extended, this desire to provide universal health care undermines capitalist and federalist principles.

Additionally, such a broad lending could lead to an inapposite result in that moderate income or upper-middle class individuals who purchase group insurance or are covered by an HMO may be denied coverage by their private insurers, but the poorest people could receive any and all medically necessary treatment under Medicaid. Therefore, the Eighth, Ninth, and Tenth Circuits' interpretation of Title XIX gives too much influence to treating physicians and unduly reduces states' legislative discretion. In doing so, these circuits ignore the statutory language "as far as practicable"¹²⁰ and disregard Medicaid's foundational federalist principles.

In addition, the Tenth Circuit's focus on whether a state's denial of Medicaid coverage for a medically necessary treatment or a

116. See *supra* notes 12-23 and accompanying text.

117. See *supra* note 1 and accompanying text.

118. See *supra* notes 17-21 and accompanying text.

119. See *supra* notes 69-102 and accompanying text.

120. 42 U.S.C. § 1396 (1994); see *supra* note 30.

medically necessary device impermissibly discriminates based on an individual's diagnosis or condition is legally unsupported.¹²¹ In applying Title XIX's mandate that states may not discriminate based on an individual's diagnosis or condition, the Tenth Circuit seems to rely on an Equal Protection analysis. This reliance on Equal Protection is misplaced, because even if a Medicaid recipient can prove that he is part of an identifiable group,¹²² the claim would likely receive only the lowest level of scrutiny under Equal Protection and the state's denial of Medicaid coverage would be upheld.¹²³

In addition, courts should not give undue deference to the HCFA's letter addressed to State Medicaid Directors.¹²⁴ Traditionally, courts give a great amount of deference to letters and guidance issued by the agency charged with administering an Act, but with respect to Medicaid, HCFA is not solely responsible for administering Title XIX.¹²⁵ Title XIX specifically delegates administrative duties to participating states.¹²⁶ HCFA's attempt to influence unduly state administration is a breach of Medicaid's federalist-based principles. States have particularized knowledge about their budgetary constraints and other needs that must be balanced with health care (such as roads, schools, low income housing, etc.), they must not give undue deference to the HCFA's letter forbidding use of a population as a whole test.¹²⁷

121. See *supra* notes 91-95, 99-100 and accompanying text.

122. A reasonable, hypothetical classification would be a group of very poor people who live in an inner city or near a toxic landfill where they are exposed to toxic chemicals on a regular basis and have developed some sort of multiple chemical sensitivity. Unfortunately, this syndrome is not universally recognized by the courts, nor scientifically or medically proven to exist.

123. Rational basis review is the lowest level of scrutiny under Equal Protection analysis and rarely if ever is capable of deeming an Act unconstitutional. See generally 16 B AM. JUR.2D § 792 (1998).

124. See *supra* notes 103-12 and accompanying text.

125. See *supra* notes 12-14 and accompanying text.

126. See *id.*

127. See *supra* note 68 and accompanying text.

VIII. PROPOSAL

On remand, the Second Circuit should not capitulate and give undue deference to the HCFA's letter.¹²⁸ The Second Circuit should adhere to its population as a whole test in order to ensure states' economic viability, uphold their role in Medicaid's federalist structure, and ensure continued participation in the program. The Second Circuit should follow HCFA's letter only to the extent that it recommends timely coverage, petition processing, and frequent updating of pre-approved coverage lists.¹²⁹

IX. CONCLUSION

Medicaid beneficiaries are not entitled to blanket coverage for all medically necessary treatment or equipment under Title XIX. The Second Circuit was justified in establishing a population as a whole test under Medicaid's federalist structure and should not give undue deference to HCFA.

128. See *supra* notes 103-12 and accompanying text.

129. See *supra* notes 109-22 and accompanying text. If appealed to the United States Supreme Court, the Court should uphold this position based on *Alexander v. Choate*. For discussion of *Alexander*, see *supra* notes 38-43 and accompanying text.